# Medicaid Transformation
# HBs 7223 & 7225

House Select Policy Council on Strategic & Economic Planning

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# The Florida Medicaid Program

- Entitlement program in which the states voluntarily participate.
- Combination of Federal and State taxpayer funds to provide free health care for eligible populations.
- More than 2.7 million Floridians are currently enrolled.
- Routine medical care—like private insurance—but also covers long term care, specialized residential services, and a variety of home and community based care.

# Problems: Access and Quality

- Patients cannot access specialists or may travel long distances to receive specialty care.
- Some patients are forced to drive past Medicaid providers who will not see them in order to access the providers who will.
- In some cases, the van drivers are paid more than physicians.

# Problems: Cost

- FY 1999/2000, total expenditures for Florida Medicaid:
  - $7.42 billion (17.8% of the total state budget).
- FY 2009/2010, total estimated expenditures for Florida Medicaid:
  - $18.81 billion (28.3% of the total state budget).
- If the growth rates continue at the same levels as they have averaged over the last twelve years, by FY 2014-15 Medicaid expenditures are estimated to be:
  - $28.0 billion (33.4% of the total state budget).

# Problems: Systematic Failures…

- Inefficient service delivery:
  - Needed services may not be available or accessible.
- Uneven quality of services:
  - Lack of systemic quality protection or incentives for continuing improvements.
- Overutilization:
  - Lack of coordinated care results in hospitalizations that should have been preventable (and often times inappropriate) use of emergency care.

# ...Problems: Systematic Failures

- Rising cost of care:
  - Medicaid costs continue to rise despite many containment efforts.
- Fraud and abuse:
  - "Pay and chase" fraud fighting is ineffective;
  - Prevention have a modest impact in fee-for-service.
- Low rates for fee-for-service providers:
  - Fees for many physician services have not increased in 20 years.

# Why Systemic Change?...

- Current system too complex:
  - Multiple managed care models;
  - Unlimited providers;
  - County-by-county contracting.

- Difficult to manage:
  - 80,000-100,000 fee-for-service providers;
  - Complex rate-setting with multiple variations;
  - 23 managed care organizations including 16 HMOs and 7 PSNs (more than 150 separate contracts);
  - Dozens of individual programs and projects.

# ...Why Systemic Change?

- Reflects inconsistent principles:
  - Current statutory framework represents no clear linkage to overarching mission of Florida's Medicaid program.

- Controlled by special interest carve outs, exceptions, preferences:
  - Exceptions for specific service types or populations;
  - Special projects operate only in selected areas;
  - Vendor-specific preferences.

# Principles of Proposed Transformation…

- Continuous quality improvement:
  - Accountability through appropriate reporting and measurement;
  - Transparency of performance metrics and data;
  - Consequences for performance.

- Efficient service delivery:
  - More coordinated care;
  - Better network development and oversight.

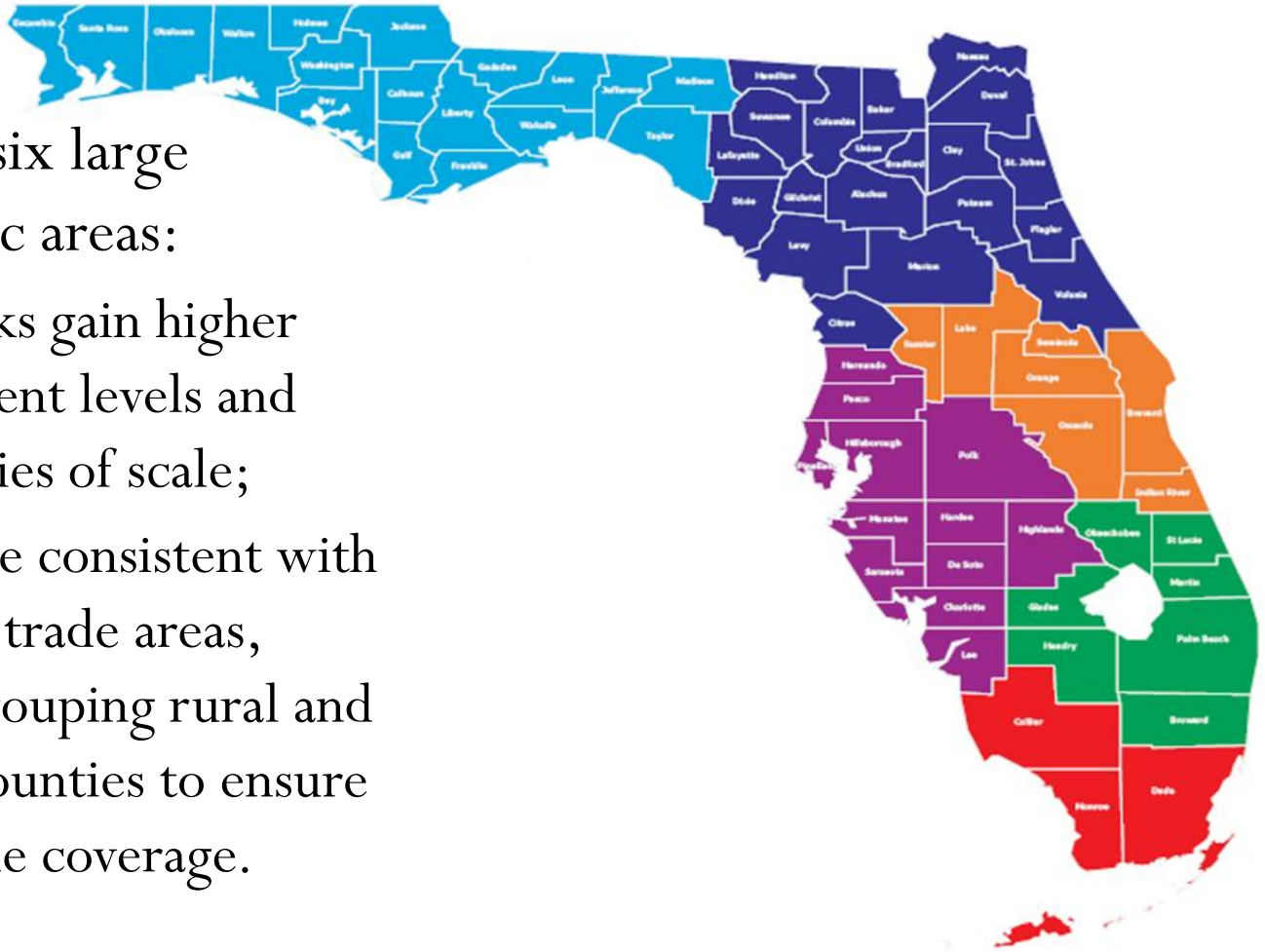
# ...Principles of Proposed Transformation

- Predictable spending levels:
  - Increased use of pre-paid financing systems;
  - Cost containment through care coordination and incentives for system improvement;
  - Smarter purchasing practices.

- Patient centered care systems:
  - Encourage specialty networks to cater to unique patient needs;
  - New requirements for plans to communicate with consumers;
  - Incentives for healthy behaviors enabling patients to purchase additional services ;
  - Flexibility for use of resources allowing patients to purchase private insurance and other health care services.

# Administrative Reforms…

- Regions: six large geographic areas:
  - Networks gain higher enrollment levels and economies of scale;
  - Areas are consistent with medical trade areas, while grouping rural and urban counties to ensure statewide coverage.



# Administrative Reforms…

- Limited number of plans: minimum of 3 (except for the developmentally disable) and maximum of 10 in a region:

| Medical and Long Term Care | Area 1 | Area 2 | Area 3 | Area 4 | Area 5 | Area 6 | Total Statewide |
|---|---|---|---|---|---|---|---|
| Total Enrollees | 203,337 | 433,428 | 692,564 | 370,747 | 426,008 | 552,024 | 2,678,108 |
| Minimum plans | 3 | 4 | 5 | 4 | 4 | 5 | 25 |
| PSN plans if responsive | 1 | 1 | 2 | 1 | 1 | 2 | 8 |
| Maximum plans | 3 | 7 | 10 | 8 | 7 | 9 | 44 |
| DD plans Min – Max (1 PSN each) | 2 | 2 - 5 | 3 - 6 | 3 - 6 | 3 - 6 | 3 - 6 | 16 - 31 |

  - Small enough to make the system easier to manage;
  - Large enough to promote competition and prevent dependency on a small number of vendors.

# ...Administrative Reforms...

- Better control by AHCA:
  - Periodic procurements/ongoing monitoring;
  - Upfront evaluation of plan qualifications and capabilities;
  - Focus on Accountability: Medical loss ratios with consequences;
  - Focus on Accountability: Authority to set specific performance expectations and impose consequences;
  - Sanctions for early withdrawal.

# ...Administrative Reforms

- More information / encounter data:
  - All plans required to submit;
  - Data to be used in rate-setting and performance evaluation.

- Greater transparency
  - Reporting of medical loss ratios
  - Better information about plans' providers
    - Online database
    - Customer feedback capability

# Impacts: Patients

- Most patients will be enrolled in managed care plans:
  - Choice of plans
    - May be fewer plans in some areas but still 3-10 options
    - Choices will include HMOs and PSNs
    - Some choices may be specialty plans
  - Network transparency
    - Easier to find out what providers are in what plan
    - Easier to learn about specific providers
    - Option to express opinions about specific providers
  - Quality assurance: easier to get performance information
  - Reliability: plans less likely to withdraw

# Impacts: Physicians...

- Most patients will be enrolled in managed care plans.
- Physicians will interact with fewer plans.
- Potential for more physicians to participate in Medicaid:
  - Better monitoring of network adequacy will cause plans to actively work to recruit and retain physicians.
- Option to become or participate in medical homes:
  - Selection criteria favor medical home networks;
  - Medical home networks certified by AHCA must pay physicians at least 80% of Medicare rates.

# ...Impacts: Physicians

- Possibility for higher payment rates:
  - For plans to be selected, they must demonstrate they meet specific standards for provider networks;
  - Selection criteria favor plans that improve compensation for primary and specialty physicians;
  - Requirements for performance incentives will lead to better compensation for quality care.

# Impacts: Hospitals…

- Most patients will be enrolled in managed care plans.
- Hospitals will interact with fewer plans.
- Hospitals' negotiation with plans prior to the competitive procurement may help some plans to be selected over others.
- Hospitals will be paid the rates the agency would have paid or better based on their negotiations with the plans.

# ...Impacts: Hospitals

- Contingent on federal approval, the hospitals in counties that contribute IGTs will receive special supplemental payments from managed care plans.
- Specific hospitals, with certain state-recognized status, will have to participate in all selected plans in their region.
- Medicaid patients use of hospital services may decrease over time as care is better coordinated and managed.
- Hospitals may form PSNs and compete to be selected by the agency; if a responsive bid is submitted, at least one PSN will be selected in each region.

# Impacts: HMOs...

- Most patients will be enrolled in managed care plans.
- Some HMOs will be selected by the agency.
- Some will not.
- To be selected, HMOs will have to document their ability to meet rigorous standards for network adequacy and other criteria.

# ...Impacts: HMOs

- Once selected, HMOs will have to meet specific performance standards and maintain an online database of network providers.

- HMOs will have to spend at least 85% of premium revenues for medical care and direct case management or payback the difference.

- HMO enrollment can be increased or decreased based on quality performance.

# Impacts: Nursing Homes…

- Medicaid patients in nursing homes will be enrolled in managed care plans.
- AHCA will continue to set nursing home rates.
- Selected plans will be required to pay AHCA rates.
- Nursing homes may form Provider Service Networks and compete to be a selected plan; if a responsive bid is submitted, at least one PSN will be selected in each region.

# ...Impacts: Nursing Homes

- Over time, the number of Medicaid patients in nursing homes will decline.
- No new nursing homes will be built.
- Nursing homes will be relieved of minimum Medicaid utilization requirements.
- A task force will develop recommendations for licensure flexibility that will help nursing homes modify their business model to provide more home and community based care.

# Impacts: Specialty Providers...

- Long term care plans must include traditional aging service providers.
- Aging Resource Centers must be offered the chance to be the choice counseling contractor in their areas.
- Long term care service providers and community care lead agencies may form provider service networks.

# ...Impacts: Specialty Providers

- Plans for persons with developmental disabilities must include all ICF/DDs and alternative residential service providers.
- DD providers may form provider service networks.
- If a responsive bid is submitted, at least one PSN will be selected in each region.

# Impacts: Taxpayers

- Real cost savings:
  - General revenue savings will be between $3.2 and $16 million in FY 2010-11 as a result of expansion of reform to Miami-Dade and enrolling duals in managed care;
  - Annualized savings in the following year are estimated at $29.6 million contingent on agreement from CMS regarding IGT payments;
  - With statewide managed care expansion, particularly long-term care managed care, the state is expected to realize significant additional savings.

# Summary of Outcomes

- Changes to Florida Medicaid will make the program more:
  - Patient-centered;
  - Prevention focused;
  - Outcome-oriented; and,
  - Cost-effective.

- And there will be peace on earth.